(2) (3) (2)

Supreme Court, U.S.
FILED
APR 7 1994
OFFICE OF THE CLERK

Nos. 93-1408, 93-1414 and 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

MARIO M. CUOMO, ET AL.,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(For Continuation of Caption See Reverse Side of Cover)

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF IN OPPOSITION

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NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Whether the United States Court of Appeals for the Second Circuit correctly applied this Court's Employee Retirement Income Security Act of 1974 ("ERISA") preemption cases, which time and again have invalidated State laws that "relate to" ERISA plans, in enjoining enforcement of State statutory hospital surcharges that drive ERISA plans' choices among alternative forms of health care coverage.

2. Whether the United States Court of Appeals for the Second Circuit correctly applied this Court's precedents in holding that certain of the challenged surcharges are not "saved" from preemption as laws regulating the business of insurance.

3. Whether the United States Court of Appeals for the Second Circuit correctly interpreted certain provisions of the Federal Employees Health Benefits Act ("FEHBA") as requiring preemption of certain of the challenged surcharges, and correctly deferred to the reasonable interpretation of that statute made by the agency charged with its enforcement.

RULE 29.1 STATEMENT

This brief in opposition is submitted on behalf of the following respondents, whose parent companies and subsidiaries (except wholly-owned subsidiaries) are indicated below, pursuant to Supreme Court Rule 29.1.

1. **The Travelers Insurance Company**
   Parents: The Travelers Inc. (formerly Primerica Corporation, successor to The Travelers Corporation); Associated Madison Companies, Inc.; and The Travelers Insurance Group Inc.

   Subsidiaries: Commercial Credit Company; Smith Barney Shearson Holdings Inc.; and Travelers Mortgage Securities Corporation.

2. **Health Insurance Association of America**
   None.

3. **American Council of Life Insurance**
   None.

4. **Life Insurance Council of New York, Inc.**
   None.

5. **Aetna Life Insurance Company**
   Parent: Aetna Life and Casulty Company.

   Subsidiaries: Aetna Health Plans of Colorado, Inc.; Aetna Health Plans of Florida, Inc.; Aetna Health Plans of San Diego, inc.; Partners Health Plan of Pennsylvania, Inc.; Aetna Series Fund, Inc.; HEALTHWAYS, Inc.; Med Southwest, Inc.; and PHPSNE Parent Corporation.

6. **Aetna Health Plans of New York, Inc.**
Parents: Aetna Life and Casualty Company; Aetna Life Insurance Company; AHP Holdings, Inc.; and HEALTHWAYS Systems, Inc.

7. **Mutual of Omaha Insurance Company**
Subsidiary: Preferred HealthAlliance, Inc.

8. **The Union Labor Life Insurance Company**
None.

9. **Professional Insurance Agents of New York, Inc. Trust**
None.

Respondents Health Insurance Association of America, American Council of Life Insurance and Life Insurance Council of New York, Inc. are independent trade associations. Their members number in the hundreds, and a listing of these members is set forth at "Addendum A" to respondents' brief in the United States Court of Appeals for the Second Circuit.

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BRIEF IN OPPOSITION

In their zeal to obtain further review, petitioners[1] have misrepresented the breadth of the Second Circuit's decision and its potential impact. In this Court, as in the courts below, petitioners have characterized this case as a challenge to a State's power to regulate hospital rates. This is fundamentally wrong. The issues presented by this case are far narrower, and do not warrant consideration by this Court.

This case involves New York State's attempt to drive ERISA plans' choices among alternative forms of health care coverage for their participants and beneficiaries. Essentially, New York State created a series of surcharges which were designed to force ERISA plans to provide their members with coverage for inpatient hospital care through New York's publicly-subsidized Blue Cross system, rather than through commercial or self insurance. In finding that the surcharge laws at issue "relate to" ERISA plans and are not "saved" as laws regulating the business of insurance, the Second Circuit did nothing more than apply this Court's well-established interpretation of ERISA's

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[1] In No. 93-1408, the petitioners are the New York State Conference of Blue Cross & Blue Shield Plans and Empire Blue Cross and Blue Shield (collectively, "the Blues"). In No. 93-1414, the petitioners are New York State officials who (or whose predecessors) were defendants in the District Court. Herein, these petitioners will be referred to as "the State" or "New York State." In No. 93-1415, the petitioner is the Hospital Association of New York State ("HANYS").

preemption clause -- a clause this Court has described as "conspicuous for its breadth."

Moreover, the decision of the Second Circuit will have little impact on the functioning of New York's system of reimbursement for hospital care. Respondents have always paid (and continue to pay) the 13% surcharge. They did so while their challenge to it was pending in the District Court; shortly after the District Court upheld the challenge and enjoined New York State from enforcing the 13% surcharge, it granted a motion to stay this injunction pending appeal. On August 10, 1993, before the Second Circuit ruled on petitioners' appeal, Congress passed the Omnibus Budget Reconciliation Act of 1993 (the "Budget Act"). Section 13442 of the Budget Act amends Section 162 of the Internal Revenue Code, which governs trade or business deductions.[2] Essentially, Section 13442 operates as follows: for services provided after February 2, 1993, and on or before May 12, 1995, employers will lose their tax deductions for any amounts paid or incurred in connection with their group health plans if these plans do not pay the challenged surcharges in connection with their reimbursement for inpatient hospital care services provided in the State of New York. Because of the enormous financial incentive ERISA plans face to do so, all of the respondents are paying the 13% surcharge despite their preemption victory in the Second Circuit.[3] Further, in the face of

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[2] Section 13442 is reproduced at Addendum 1 to this brief.

[3] As noted, on February 9, 1993, the District Court stayed its February 3 order enjoining enforcement of the surcharges -- but only with respect to the 13% surcharge. (*See* A-94 to A-98.) For this reason as well, the respondents are paying it. Should this Court

(continued...)

respondents' successful challenge below, the New York Legislature recently re-enacted the 13% surcharge. (*See* Blues' Petition at p. 5.) As a consequence of the Budget Act and reenactment of this differential, New York hospitals will continue to receive the 13% surcharge. Thus, any pronouncement by this Court on the merits of the Second Circuit's decision regarding the 13% surcharge would amount to a mere advisory opinion.

Second, the 11% surcharge no longer exists. By the terms of the statute creating it, it was to apply only to hospital patients discharged during the period April 1, 1992 to March 31, 1993. Since this surcharge has lapsed by operation of the statute creating it, the decision of the Second Circuit regarding this issue has no prospective significance or impact, and the Second Circuit's rulings thereon do not warrant certiorari.

In addition, contrary to petitioners' contentions, there is no conflict between the Second Circuit's decision in this case and the Third Circuit's decision in *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993). *United Wire* is distinguishable for the reasons stated below.

Finally, petitioners argue that the issues presented herein are of substantial national importance because the Second Circuit's ruling threatens the power of the States to exercise one of their fundamental police powers: "the regulation of health care and the control

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[3](...continued)
deny review, the Second Circuit's mandate will issue shortly thereafter, thus dissolving the District Court's stay order.

of its costs." (*See, e.g.*, HANYS's Petition at p. 16.) The issues in this case, however, involve much narrower, straightforward questions of ERISA and FEHBA preemption. The Court of Appeals correctly resolved these questions. Finally, the many district court cases petitioners cite (*see* State's Petition at 14-15 n.10; Blues' Petition at 18 n.25; HANYS's Petition at 18), in an attempt to demonstrate the national importance of this case, are totally inapposite. Unlike those cases, this case does not involve a challenge to the DRG rate-setting system. It does not call into question bad debt and charity care allowances or balance billing laws.

COUNTERSTATEMENT OF THE CASE

A. General Background.

In the District Court, respondents established that most Americans (excluding those qualifying for programs like Medicare and Medicaid) receive their health care coverage through employee welfare benefit plans governed by ERISA (JA-373-74, 379, 386-87, 391, 403).[4]

Employers and other plan sponsors that establish welfare plans subject to ERISA provide health and hospital coverage to their employees through a variety of methods, including (a) commercial health insurance contracts; (b) self insurance (in which a plan is directly responsible for medical and hospital bills and may or may not carry excess liability coverage); (c)

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[4] The Joint Appendix filed in the United States Court of Appeals for the Second Circuit will be cited herein as "(JA-___)." The separately bound Appendix filed in this Court with the petitions for certiorari will be cited as "(A-___)."

subscriptions to an HMO; or (d) coverage through a non-profit corporation such as Blue Cross/Blue Shield. (JA-372.)

An ERISA plan using commercial health insurance contracts with an insurer which reimburses certain health care costs incurred by plan participants and their beneficiaries, in exchange for a premium calculated to cover the costs of paying claims and administering the policy.

ERISA plans that are self-insured directly assume responsibility for the costs of health care, including in-patient hospital care, for their participants. Under some self-insured plans, the employer covers the full cost of the covered health care; under others, contributions from employees are required. Employers frequently retain a commercial insurer to administer claims and perform other administrative functions for self-insured plans. (JA-373.)

ERISA plans that use HMOs pay the HMO a predetermined premium or rate in return for providing health care services to plan participants. (JA-373.)

The Blues are non-profit corporations organized pursuant to Article 43 of the New York Insurance Law. These corporations contract directly with hospitals to provide services to individuals or members of groups subscribing to Blue Cross/Blue Shield.

B. New York's Approach to Hospital Rate Regulation.

New York State regulates the rates at which hospitals are reimbursed for the costs of in-patient care. For most patients, the rates for in-patient hospital care

are set on the basis of categories relating to the diagnoses of patients' illnesses. These categories are known as "Diagnosis Related Groups," or "DRGs." Pursuant to this system, the amount charged for in-patient hospital care is set on the basis of the DRG in to which the patient falls rather than on the actual cost of treatment. Furthermore, the actual amount charged for in-patient hospital care varies depending on the type of health care coverage -- *i.e.*, self insurance, commercial insurance, HMO membership or Blue Cross/Blue Shield -- provided to the patient.

New York Public Health Law Section 2807-c(1)(b) requires that the DRG rate for in-patient services be increased by a 13% surcharge when the patient is covered by any form of health plan (including, specifically, commercially-insured and self-insured employee benefit plans), except for patients covered by the Blues, an HMO, or government plans like Medicare. (A-102 to A-103.) The funds generated by the 13% surcharge are retained by hospitals, and are available to cover all of the operating and capital expenses of their business. (JA-1260.)

In the District Court, the State conceded that the purpose of the 13% surcharge was to encourage users of hospital services to select Blue Cross coverage. For example, James W. Clyne, New York's Deputy Superintendent of Insurance, stated that the 13% differential was meant to "level the playing field" for the Blues "in their competition with commercial insurers . . . ." (JA-649; *see* New York State's Memorandum of Law in Opposition to Plaintiffs' Motions for Summary Judgment at 37.)

Section 348 of New York's Omnibus Revenue Act of 1992, adopted on April 2, 1992 (the "Omnibus Act"),

amended Section 2807-c of New York's Public Health Law to impose an additional 11% surcharge on DRG payment rates charged by hospitals to patients covered by commercial insurance. Consequently, the total surcharge for commercially-insured patients -- and thus the differential between the Blues' and commercial insurers' charges -- was raised to 24%. (A-104.)[5]

In contrast with the funds generated by the 13% surcharge, however, the proceeds of the 11% surcharge ultimately were to be paid to New York State. They were not used to reimburse hospitals. Section 349 of the Omnibus Act required hospitals to submit the funds raised by the 11% surcharge to a pool established by the Commissioner of Health, who, in turn, was required to deposit those monies into New York's general fund. (A-105.) Petitioner HANYS, which certainly is in a position to know, admits that the 11% surcharge was "not used to meet the costs that hospitals must incur. Rather, [it was] a means to raise revenue for the State." (HANYS's Petition at pp. 5-6 n.3.) The State concurs: "The 11% surcharge was enacted primarily to remedy the deterioration in the Blue Cross plans' financial position . . . . It was also intended to raise revenue for the State." (New York State's Petition at p. 6; *see also* Blues' Petition at p. 5.)

The Omnibus Act also imposed a new surcharge on HMOs. Section 346 of the Act sets forth several methods for determining the standardized rate applicable to in-patient care rendered to HMO subscribers, ranging from the DRG rate to standardized

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[5] The 11% surcharge was created to apply to patients discharged during the one-year period from April 1, 1992 through March 31, 1993. (A-104.) Accordingly, the 11% surcharge lapsed long ago.

rates negotiated by the particular HMO. It also amends New York's Public Health Law to impose a surcharge of up to 9% on the cost of in-patient hospitalization paid by HMOs. This surcharge may be reduced for HMOs that provide certain services or achieve certain goals or may be partially or totally eliminated in some circumstances. (A-106 to A-107.) Section 346 requires each HMO to pay the amount it owes each month for the HMO surcharge into a statewide pool to be established by the Commissioner of Social Services of New York State, for deposit in to the State's general fund. (A-111.) Like the 11% surcharge, the 9% assessment has nothing to do with hospital reimbursement. It is a means to raise revenue for New York State. (HANYS's Petition at 5-6 n.3.) Thus, contrary to petitioners' assertions, the surcharge laws at issue in this case have nothing to do with hospital cost containment.

In the District Court, the State and the Blues characterized the 11% surcharge as a mere extension of the 13% surcharge, contending that the function of both is to level the competitive playing field between the Blues (on the one hand) and the commercial insurance industry (on the other). The Blues frankly admitted in the court below that one of the points behind increasing the 13% surcharge to 24% was to make purchasers of commercial health insurance, which are overwhelmingly ERISA plans, "think twice as hard" about using a commercial insurer rather than the Blues. (JA-821; *see also* JA-978-79.)

C. The Impact of the Surcharge Laws.

New York's surcharges substantially increase the costs to ERISA plans of providing benefits, if the ERISA plans provide such benefits through commercial

insurance, self insurance, or HMOs. Because self-insured plans undertake to pay for covered medical services provided to their participants, they must directly pay the 13% surcharge. Similarly, commercial insurance policies often provide that the premiums charged will depend on the amount of benefits paid. In those situations, the plans bear the 13% and 11% surcharges. More generally, the premiums charged for insurance, or the fees charged by HMOs, must be set at a level that will recapture the costs of providing benefits. State laws increasing those costs -- here, the 13%, 11% and HMO surcharges -- directly increase the amounts that ERISA plans must pay to provide a given level of benefits. (JA-388, 391, 396, 404.)

In the court below, respondents demonstrated the financial impact of the surcharges. The Second Circuit specifically found that the "surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits[,]" thus leading ERISA plans "to increase either plan costs or reduce plan benefits." (A-23.)

Thus, when a plan sponsor chooses self insurance, commercial insurance or an HMO to provide benefits, it must either pay higher costs reflecting the surcharges to provide the same level of benefits, or it must reduce benefits to offset these additional costs. Moreover, these additional costs inevitably divert plan resources from the provision of health care benefits to plan participants, in order to subsidize the general revenue needs of the State of New York (in the case of the 11% and 9% surcharges) or hospitals' general revenue needs (in the case of the 13% surcharge). The impact of these surcharges has been enormous, costing plan sponsors or plan participants hundreds of millions of dollars annually.

D. Proceedings in the District Court.

In two separate actions that were consolidated before Judge Freeh in the Southern District of New York, respondents challenged each of the surcharges as preempted by ERISA.

Respondents did not challenge New York's ability to regulate hospital rates through the use of a DRG system. Nor did they challenge the bad debt and charity care components of New York's DRG system.

Respondent Mutual of Omaha Insurance Company also maintained that the 11% and 13% surcharges are preempted by FEHBA. On cross-motions for summary judgment, the District Court issued an opinion and order on February 3, 1993 sustaining respondents' challenges.

First, Judge Freeh found that the surcharges have the requisite "connection with" ERISA plans, and therefore "relate to" such plans, because they were designed to drive ERISA plans' choices regarding the form of health care coverage to furnish their participants; and they have a significant economic effect on commercial carriers and HMOs providing coverage to ERISA plans. (A-72.)

Next, Judge Freeh found that the surcharges are not "saved" from preemption as laws regulating the business of insurance.[6]

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[6] In both the District Court and the Court of Appeals, petitioners did not raise the savings clause issue with respect to the 9% surcharge. Accordingly, the savings clause discussion in the text is limited to the 11% and 13% surcharges.

Finally, Judge Freeh rejected petitioners' contention that FEHBA's preemption provision applies only to state "premium taxes," and ruled that the 11% and 13% surcharges are preempted by FEHBA. In doing so, he deferred to the reasonable interpretation accorded FEHBA's preemption provision by the Office of Personnel Management ("OPM"), the federal administrative agency that administers the FEHBA program.

On subsequent motions, the District Court stayed its ruling regarding the 13% surcharge.

E. Proceedings in the Second Circuit.

In a carefully balanced opinion, the Second Circuit concluded that the surcharge laws were preempted by ERISA and FEHBA and affirmed Judge Freeh's order as to these issues. Nothing in the Second Circuit's opinion casts doubt on New York's ability to regulate hospital rates.

The Second Circuit found that the challenged surcharges have the requisite "connection with" ERISA plans. First, the court noted that the 11% and 13% surcharges were designed to increase hospital costs for patients covered by health plans other than the Blues, thus making these competing plans less attractive than the Blues. (A-22.) It was thus "[o]bvious[]" that the surcharges will affect ERISA plans' health care benefits. Further, the 9% surcharge imposed on HMOs would interfere with a plan's selection of the most effective method to provide benefits. The Second Circuit had little difficulty in concluding, based upon the foregoing, that the surcharges "purposely interfere with the choices that ERISA plans make for health care coverage." (A-

22.) The court found such interference sufficient to constitute "connection with" ERISA plans. *(Id.)*

The Second Circuit also found that the surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits. For this reason as well, the court found a sufficient impact with ERISA plans to constitute the requisite relation to ERISA plans. (A-23.)

The Second Circuit next affirmed Judge Freeh's ruling that the challenged surcharges are not saved from preemption as laws regulating the business of insurance. (A-25 to A-29.)

Finally, the Second Circuit rejected petitioners' interpretation of FEHBA. The court found that despite petitioners' references to the legislative history, they selectively ignored legislative policies that counter their interpretation of the statute. (A-15 to A-16.) Finally, the Second Circuit found that the District Court properly deferred to OPM's FEHBA interpretation and OPM regulations, and affirmed Judge Freeh's FEHBA preemption ruling.

On petitioners' motions, the Second Circuit stayed its mandate, pending disposition of the petitions for certiorari in this Court.

REASONS FOR DENYING THE WRIT

POINT I

THE SECOND CIRCUIT CORRECTLY APPLIED THIS COURT'S ESTABLISHED CONSTRUCTION OF ERISA's "RELAT[ING] TO" CLAUSE

Petitioners argue that the Second Circuit's ERISA preemption ruling merits review in this Court because of an alleged conflict in the circuits, and because the Second Circuit supposedly misread this Court's "relating to" precedents, thereby impermissibly expanding the scope of ERISA preemption to include laws of general application with merely remote, indirect effects on ERISA plans. None of these contentions is true.

In finding the challenged surcharges preempted in this case, the Second Circuit did nothing more than give effect to the broad, common-sense meaning that this Court has ascribed to ERISA's preemption clause time and time again. Nothing in the Second Circuit's opinion undermines a state's ability to regulate hospital rates.

This Court has repeatedly held that a law "relate[s] to" an ERISA plan, and is preempted, if it has a "connection with" or "reference to" such a plan. *See District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580, 583 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-39 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97 (1983).

In the District Court, New York State conceded that the purpose of the 13% surcharge was to encourage users of hospital services to select Blue Cross coverage. Thus, an official in the New York State Department of Insurance stated in an affidavit that the 13% surcharge was meant to "level the playing field" for the Blues "in their competition with commercial insurers . . . ." (JA-649.) In its brief in support of its motion for summary judgment, the State maintained:

> Just as the 11% is aimed at the insurance industry, so is the 13% which is, likewise, intended to level the playing field between Blue Cross and the commercial insurers.

(New York State's Memorandum of Law in Opposition to Plaintiffs' Motions for Summary Judgment at 37.) In the District Court, the Blues frankly admitted that one of the points behind increasing the 13% surcharge to 24% was to make purchasers of health insurance, which petitioners never disputed are overwhelmingly ERISA plans, "think twice as hard" about using a commercial insurer, rather than the Blues, to provide health coverage to group members. (JA-821; JA-978-79.)

These admissions demonstrate that the 11% and 13% surcharges were specifically designed to influence the choices of ERISA plans regarding the form of health care coverage furnished their participants and beneficiaries.

With these candid admissions on the record, as well as the evidence respondents adduced demonstrating the significant financial impact of the surcharges, the Second Circuit was on solid ground when it concluded:

> The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. *Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans.*

(A-22; emphasis added.)

Contrary to petitioners' contention, this unremarkable ruling is not in conflict with the Third Circuit's recent decision in *United Wire*, for the following reasons.

First, the cases are distinguishable on their facts. In *United Wire*, New Jersey officials did not admit, as New York officials did in this case, that any of the challenged components of New Jersey's hospital rate-setting scheme were specifically designed to make ERISA plans "think twice as hard" about choosing a particular form of health coverage. In light of the fact that the Third Circuit majority held that a law relates to an ERISA plan if it, *inter alia*, is "specifically designed to affect employee benefit plans," 995 F.2d at 1192 (footnote omitted), it remains an open question how the Third Circuit would rule were such an admission placed before it. For this reason alone, there is no conflict between the circuits.

Second, in reaching its decision, the *United Wire* court explicitly relied on the Second Circuit's ten-year old ruling in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

Rebaldo involved an ERISA preemption challenge, brought by a self-insured plan. The Second Circuit held that ERISA did not preclude New York from regulating hospital rates charged for services covered by self-insured plans by, among other things, preventing such plans from negotiating discounts with hospitals. In rejecting this challenge, the Second Circuit held that

> a state law must 'purport[] to regulate . . . the terms and conditions of employee benefit plans' to fall within the preemption provision.

749 F.2d at 137.

Like respondents did below, the *United Wire* plaintiffs argued that *Rebaldo* was no longer good law in light of this Court's ruling in *Ingersoll-Rand*, which expressly rejected a "purport to regulate" test. 498 U.S. at 138, 141. Further, in *Ingersoll-Rand*, this Court pointed out that pursuant to its broad reading of ERISA's preemption clause, a state law may be preempted "even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Id.* at 139.

The Third Circuit stated that *Rebaldo* -- which it explicitly noted was the "most helpful" case in resolving the issue before it -- would have been decided in the same way had the Second Circuit had the benefit of *Ingersoll-Rand*'s teachings. 995 F.2d at 1193-94. Several months later, in the instant case, the Second Circuit proved the Third Circuit's prediction was faulty,

and, on the basis of *Ingersoll-Rand*, overruled *Rebaldo's* narrow reading of ERISA's preemption clause.

What this history shows is that there is no true conflict between the Second and Third Circuits; the Third Circuit quite clearly heavily relied on *Rebaldo*, and on its prediction of how the Second Circuit would have decided *Rebaldo* in light of *Ingersoll-Rand*. Now that the Third Circuit's prediction has proved to be incorrect, it remains an open question how the Third Circuit would rule on the ERISA preemption issue presented here in light of the Second Circuit's ruling below.

Finally, it must be stressed that two of the challenged surcharges in this case -- the 9% and the 11% -- have nothing to do with hospital reimbursement, or the containment of hospital costs. The funds associated with these surcharges end up in New York State's general fund. The Third Circuit had nothing of this kind before it.[7] Once again, therefore, it remains an open question how the Third Circuit would rule on the surcharges at issue in this case.

In sum, the Second Circuit correctly applied this Court's precedents in the ERISA preemption area, and properly found that the challenged surcharges "relate to"

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[7] In fact, it was dealing with just the opposite. Thus, at one point in its analysis, the District Court in *United Wire* concluded that "[t]he state never uses the money collected from plaintiffs for the general welfare. Additionally, the fees collected are never intermingled in a general fund." *United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital*, 793 F. Supp. 524, 531 (D.N.J. 1992), *rev'd on other grounds*, 995 F.2d 1179 (3d Cir.), *cert. denied*, 114 S. Ct. 382 (1993). This finding was not disturbed by the Third Circuit.

ERISA plans. It did not, as petitioners contend, destroy a state's ability to regulate hospital rates, establish and maintain a state's DRG system or set up bad debt and charity care components in its overall hospital rate-setting system. These issues were not before the Court of Appeals. Finally, the Second Circuit did not place itself in conflict with the Third.

For these reasons, a writ of certiorari should not issue.

POINT II

THE SECOND CIRCUIT CORRECTLY APPLIED THIS COURT'S PRECEDENTS IN CONCLUDING THAT THE SURCHARGES ARE NOT SAVED FROM PREEMPTION AS LAWS REGULATING THE BUSINESS OF INSURANCE

The Blues request this Court to review the Second Circuit's ruling that the challenged surcharges are not saved from preemption under ERISA's savings clause.[8] They do not contend that a conflict in the circuits exists as to this issue. Rather, they argue that the Second Circuit failed to follow this Court's common-sense view of the savings clause, and that it "seem[ed] to require" that all three McCarran-Ferguson criteria be satisfied for a state law to be saved from preemption. (*See* Blues' Petition at 15-16.) Neither contention has merit. They certainly do not warrant certiorari.

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[8] The Blues do not raise the savings clause issue with respect to the 9% surcharge. Accordingly, the discussion in the text is limited to the 11% and 13% surcharges.

At the outset, it is important to note that the State of New York -- the political entity which created the surcharge laws at issue in this case -- has not asked this Court to review the Second Circuit's holding that the surcharge laws are not laws regulating insurance within the meaning of ERISA's preemption clause. In fact, in the Second Circuit, the State raised this issue only with regard to the 11% surcharge. (*See* New York State's Brief at 33 n.42.) Surely, if the State of New York does not believe that the ruling of the Second Circuit will interfere with its ability to regulate insurance, there is absolutely no reason for this Court to consider the issue.

Furthermore, the Second Circuit applied settled principles to a straightforward savings clause issue. It properly engaged in the common-sense determination as to whether the challenged surcharges are laws regulating the "business of insurance." *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739-40 (1985). It then applied the three criteria the courts have established to determine whether a practice constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* *See The Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

With regard to the 11% surcharge, the Blues completely fail to mention that under Section 348 of the Omnibus Act, commercial insurers were not directly obligated to pay the 11% surcharge. The law required hospitals to add the surcharge onto the bills of patients covered by commercial insurance, and to turn the proceeds over to the State. (A-105.) If the surcharge was not paid, the hospital -- not the commercial insurer

-- could have been subject to penalties.[9] Indeed, the State deliberately chose not to impose the 11% surcharge on insurance companies in order to avoid any characterization of the law as a tax on insurers. (JA-1232.) Thus, the Court of Appeals correctly found that the 11% surcharge fails the common-sense inquiry. The real burden of paying it fell on New York hospitals.

The Second Circuit also correctly found that the 13% surcharge fails the common-sense inquiry. It governs the relationship between hospitals and their patients.

The Court of Appeals then applied the McCarran-Ferguson criteria. It found that the surcharges do not dictate any of the terms of the insurance contract itself; rather, as the Second Circuit correctly found, they relate only to the contractual obligations between hospitals and insurers or insureds. (A-29.) Further, the surcharges are not limited to entities within the insurance industry -- involving as they do the State, hospitals, patients, HMOs and self-insured funds. For the foregoing reasons, the Second Circuit concluded that the surcharges fail two of the McCarran-Ferguson criteria.

In sum, the Court of Appeals found that the surcharges are not saved from preemption because they fail the common-sense inquiry plus two of the three McCarran-Ferguson criteria. The court did not hold, as the Blues argue, that all three McCarran-Ferguson criteria must be satisfied to save a state law from preemption. Notably, the Blues have not cited any

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[9] *See* 1992 N.Y. Laws, ch. 41, § 104, *reproduced at* Addendum 2 hereto.

language in the court's opinion to that effect. Despite the Blues' complaint that the Second Circuit read the savings clause too narrowly, the court correctly balanced the legislative purposes behind the "relat[ing] to" and "savings" prongs of ERISA's preemption clause. Since the Second Circuit applied established principles in a simple factual context, there is no reason for this Court to consider the savings clause issue presented by this case.

POINT III

THE SECOND CIRCUIT CORRECTLY INTERPRETED FEHBA AS PREEMPTING THE SURCHARGES, AND CORRECTLY DEFERRED TO OPM's IDENTICAL INTERPRETATION OF FEHBA

Finally, Petitioner HANYS seeks certiorari to review the Second Circuit's ruling that FEHBA preempts the 11% and 13% surcharges. HANYS concedes that there exists no conflict in the circuits regarding this issue. It argues that FEHBA's prohibition of any tax, fee or monetary payment with respect to payments from the Federal Employee Health Benefits ("FEHB") Fund applies to premium taxes. It contends that the 13% surcharge simply determines the amounts that hospitals must bill their patients; it does not constitute an extra tax, fee or monetary payment with respect to such rates.[10]

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[10] Respondent Mutual of Omaha challenged both the 11% and 13% surcharges as preempted by FEHBA. Since HANYS makes it very clear in the initial pages of its petition that it "takes no position on the 11%" surcharge since it is simply a State revenue-raising measure and not hospital reimbursement (*see* HANYS's

(continued...)

At bottom, HANYS is asking this Court to review a ruling that is solidly grounded in: (1) the language of the statute; (2) its legislative history; and (3) a reasonable interpretation of the governing statute and applicable regulations by the administrative agency charged with administering the FEHB Program.

FEHBA, 5 U.S.C. § 8901, *et seq.* (Supp. IV 1992), creates a program under which federal employees' health coverage is paid for in part by their federal government employer. In creating this program, Congress intended to reduce the cost to the federal government of the Federal Employees Health Benefit ("FEHB") program by prohibiting, with limited exceptions, state and local governments "directly or indirectly" from taxing or surcharging any payments from the government in connection with the FEHB program. Section 8909(f) states that "[n]o tax, fee or other monetary payment may be imposed, directly or indirectly, on a carrier or underwriting plan administration subcontractor . . . by any State . . . with respect to any payment made from the Fund." (A-100.)

Respondent Mutual of Omaha sued to enjoin enforcement of the 11% and 13% surcharges as preempted by FEHBA. Petitioners cross-moved for summary judgment on the ground that FEHBA only applies to "premium taxes." The Second Circuit affirmed the District Court's rejection of this argument.

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[10](...continued)
Petition at 5-6 n.3), its petition for certiorari should be read as seeking review only of the Second Circuit's FEHBA ruling regarding the 13% surcharge. Of course, respondents' FEHBA arguments are equally applicable to both surcharges.

Both courts found that contrary to HANYS's arguments, the FEHBA statute does not clearly refer to state premium taxes. The statute itself refers only to a "tax, fee or other monetary payment" imposed "directly or indirectly" on "any payment made from the Fund." (A-85-86.) The District Court deferred to OPM's administrative interpretation that FEHBA preempts the 11% and 13% surcharges. The District Court noted that there was no dispute that the surcharges substantially increase the amount that FEHBA carriers must pay for hospital care. These carriers are reimbursed for payments by the Fund; therefore, the surcharges serve to increase payments from the Fund. Thus, OPM's determination of preemption under Section 8909(f) is a "reasonable interpretation of the statute" warranting deference. (A-86.) *See Chemical Manufacturers Association v. Natural Resources Defense Council*, 470 U.S. 116, 125 (1985); *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984).

The Second Circuit rejected petitioner's attempt to reargue these propositions on appeal. In fact, the Second Circuit explicitly noted that petitioners "selectively ignore[d] legislative policies that run counter to their interpretation of the statute." For example, the central purpose of Section 8909(f)(1) was to reduce expenditures from the Fund by preventing states from charging taxes on health care reimbursements drawn by carriers from the Fund. (A-16.) The Second Circuit also approved of the District Court's deference to OPM's administrative interpretation of Section 8909(f)(1). OPM's interpretation was rendered before the government entered this litigation. (A-17.)

Petitioners have adduced no reason why the Second Circuit's FEHBA ruling warrants this Court's

review pursuant to Supreme Court Rule 10. Accordingly, its attempt to win review of that ruling should be rejected.

CONCLUSION

For the foregoing reasons, the petitions for a writ of certiorari should be denied.

Respectfully submitted,

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Dated: New York, New York
April 7, 1994